

FOCUS: ECONOMICS

Health – sacrificing the sacred cow?



Authors: T. Moon & J. Moon

The NHS – sacrificing the sacred cow?

A sacred cow

The UK's National Health Service (NHS) is one of the few remaining “sacred cows” of our society. The promise to deliver health care that is free at the point of delivery is admirable and is an ideal that we would all like upheld. However, with the rapid and large advances that have been made in medical science over recent years, this comes at an increasingly heavy cost. Furthermore, to deliver an extensive and comprehensive service to the sixty million plus population of the UK requires a huge investment in people and assets.

Big numbers

In fact, the NHS is one of the biggest employers in the world, (only the Chinese People's Liberation Army, the Wal-Mart supermarket chain and the Indian Railways directly employ more people). Therefore, the NHS has grown to some 1,368,693 people in England (a 25.14% increase compared to 10 years ago). The NHS in Scotland, Wales and Northern Ireland employ 158,000, 71,000 and 67,000 people respectively (based on 2008 figures). This is a huge organisation; it is complex, its activities diverse and technically demanding. It is frequently the object of political interference and changing performance targets, the latest fads from management consultants and over optimistic I.T. programmes. Is it any wonder then that the bill for running the NHS was a whopping £90 billion in 2008? On top of this is the price of building programmes that are “off balance sheet” such as the PPP and PFIs.

What's more, the organisation itself is complex as the figure below illustrates:

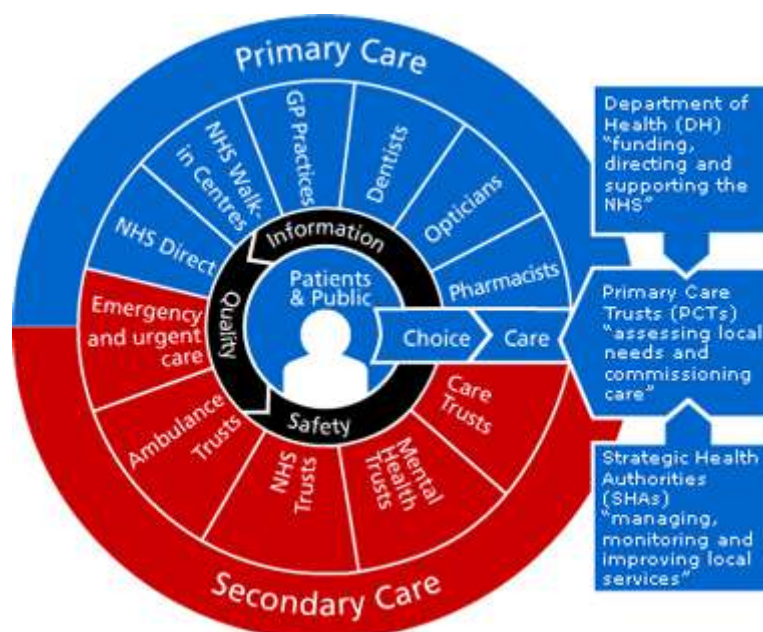


Figure 1: NHS organisation

Statistics – getting bigger all the while

Knowing that this is one of the largest organisations in the world, it should not be a big surprise to learn that the cost of management is relatively high – especially given the complex nature of the beast. Here are a few numbers that illustrate not only that the NHS is big, but that it has grown significantly over the last ten years:

Over 75% of their staff are qualified clinical staff, or employed to support these clinical staff:

- Professionally qualified clinical staff: 701,324 **(51.24%)**
- Doctors: 133,662 **(9.77%)**
- Qualified Nurses: 408,160 **(29.82%)**
- Qualified Ambulance Staff: 17,451 **(1.28%)**
- Support to clinical staff: 355,010 **(25.94%)**
- NHS Infrastructure Support: 219,064 **(16%)**
 - Central Functions: 105,354 **(7.70%)**
 - Hotel, Property & Estates: 73,797 **(5.39%)**
 - Manager & Senior Manager: 39,913 **(2.92%)**

The interesting numbers here are those for support and management staff – some 16%, a number that would be deemed way too high if this were a leading private sector organisation.

Over the last 10 years, the percentage of people employed in different job roles in the NHS has changed, highlighting how important the NHS now views some roles compared to 10 years ago. The 5 job roles with the largest percentage increase and decrease over this time are:

Increases:

1. “Other GPs”: +774.41%
2. Registrars: +189.38%
3. GP Registrars: +121.51%
4. Support to ambulance staff: +109.37%
5. Manager & Senior Manager: +75.79%

Decreases:

1. Other non-medical staff and those with unknown classification:
-81.79%
2. Hospital practitioners and clinical assistants (non-dental specialties):
-56.29%
3. Other doctors in training: -24.46%
4. GP Providers: -0.52%
5. Hotel, property & estates: -3.00%

The increases over the last decade are an attempt to increase capacity and improve services - but we have all heard tales of poor quality of care, dirty hospitals and infection by so-called “superbugs”. Is that a case of not enough people in one part of the country and too many in another? That does not appear to be the case, as the 1,368,693 people employed by the NHS are spread fairly evenly through the country, with 39.22% employed in the South

and London, 31.99% employed in the North and 27.40% employed in the Midlands and East Anglia. The other 1.39% is spread across other small Health Authorities. The largest Strategic Health Authority by number of employees is the North West with 208,983 (15.27%), and the smallest is the North East with 80,038 (5.85%).

Is bigger better?

In theory, the more people there are to treat patients, the better the care. However, illness and demand are not static, whilst capacity increases are slow and cost additional money: The UK's population is not homogenous and healthcare requirements change with demography – age, race, environment, and lifestyle.

A matter of expectation?

A major problem of the sacred cow is that the public expect everything to be available everywhere on demand; that means building in redundant capacity for some services at the expense of other (perhaps more needed) services in a particular area.

... Political interference

This is compounded by the unwillingness of politicians to take bold decisions that might be vilified in the popular press. The result tends to be either a rush to set targets (that are then manipulated by managers to demonstrate compliance) that have unintended negative consequences or a vagueness of policy that is just unhelpful in setting the direction the NHS should follow. What is more, it is nigh on impossible to look at the progress in service levels and healthcare that have taken place over the years because of constant “dabbling” with the numbers and the way they are reported by government.

...and money problems still exist

Even with the massive financial resources available to the NHS, it has to work to a budget – otherwise it has the potential to swallow up every penny of Tax revenue.

146 of the 152 Primary Care Trusts and 168 of the 178 NHS Trusts ended the year with a financial surplus and all of the 10 Strategic Health Authorities ended the year with a surplus. However, four Primary Care Trusts and seven NHS Trusts ended the year with a financial deficit, these are listed below:

Primary Care Trusts in deficit 2007-08 are:

1. **North Yorkshire and York**, deficit of £18,226,000
2. **Enfield**, deficit of £13,308,000
3. **Buckinghamshire**, deficit of £11,574,000
4. **Hounslow**, deficit of £1,940,000

NHS Trusts in deficit 2007-08 are:

1. **Barking, Havering and Redbridge Hospitals NHS Trust**, deficit of £35,621,000
2. **Bromley Hospitals NHS Trust**, deficit of £17,920,000
3. **Hinchingbrooke Healthcare NHS Trust**, deficit of £16,037,000
4. **Queen Elizabeth Hospital NHS Trust**, deficit of £3,125,000
5. **Queen Mary's Sidcup NHS Trust**, deficit of £2,877,000
6. **Newham University Hospital**, deficit of £2,269,000
7. **Hertfordshire Partnership**, deficit of £1,522,000

In addition, seven NHS Trusts are listed as financially challenged, (although not necessarily in deficit). The definition of a financially challenged trust is as follows:

- It requires a cash loan but it and its Strategic Health Authority are unable to provide sufficient assurance of its ability to generate the required level of surplus to repay a loan over a reasonable period; or

- It already has a working capital loan, but defaults on its terms, most probably by moving into deficit and so not being able to make planned repayments from generated surpluses.

The seven financially challenged trusts are:

1. **Barking, Havering and Redbridge Hospitals NHS Trust**, deficit of £35,621,000
2. **Bromley Hospitals NHS Trust**, deficit of £17,920,000
3. **Hinchingbrooke Healthcare NHS Trust**, deficit of £16,037,000
4. **Queen Elizabeth Hospital NHS Trust**, deficit of £3,125,000
5. **Queen Mary's Sidcup NHS Trust**, deficit of £2,877,000
6. **The Lewisham Hospital NHS Trust**, surplus of £3,771,000
7. **Whipps Cross University Hospital**, surplus of £828,000

NHS Foundation Trusts recorded a net surplus of £395 million (this is in addition to the £1.67 billion NHS surplus). Only one of the 89 Foundation Trusts recorded a financial deficit, this was the Royal National Hospital for Rheumatic Diseases, which had a deficit of £0.4 million.

So, is there an easy answer?

No, there isn't. Firstly, there is the whole question of the real purpose of the NHS: Is it primarily an organisation that should focus on curing illness? An organisation that should primarily focus on preventing illness? Or both?

These are different roles and have different consequences for the type of NHS the country needs – and can afford - a service focused on prevention is an education service designed to advise and persuade the public about what is best for their health. An organisation to cure illness is what we have now – a giant of a beast that will get larger and larger while our population grows and people live longer. It is also the case that people abuse the NHS and don't respect it because they take it for granted: Wasting GP's time, failing to show up for an appointment, hoax '999' calls, milking the system for sick

notes, drugs and a lack of respect for the staff. All of these are a complete waste of money.

Does that mean that the government have it right?

Yes and no: On the one hand, trying to set a central strategy whilst letting local health authorities tailor it to the needs of a local population and delivering through a set of hospitals and GPs is the right way to go. The commissioner-provider model should encourage the hospitals & GPs (providers, usually) to provide the right services, but the lack of real competition or exclusivity doesn't deliver the most efficient services. Further, it is a model still based on "the state will cure all" rather than a move towards prevention.

What about reducing costs?

There can be little doubt that the cost of the NHS could be reduced: Procurement could be more efficient (improvements have been made), contracts and service levels joined up so that third party contractors are actually contracted to deliver the exact services that hospitals etc. need (yes, it does happen that they deliver something different because the person writing the contractual agreement did not understand what was needed!); the number of managers could be reduced and support staff; IT simplified and so on. However, making these changes in isolation of addressing the fundamental questions of purpose, form and need are guaranteed just to make the service worse – cheaper, but worse.

So, what should be done?

The truth is that it will take a bold government to change direction away from feeding the beast; but it has to be done. Would a change in direction necessarily mean mass sackings and people dying from lack of care? – no.

One possible scenario would be a two pronged approach?

Firstly, the government sets a strategy for the next 25 years, agreed by a vote in Parliament and then stops tinkering and fiddling. The nature of that strategy

has to be that the tax funded NHS will become an organisation primarily aimed at the prevention of illness – an educator and consultant to the public via GPs concerning their lifestyles and ways in which they can help prevent illness. Complementing it will be an A&E capability.

Next, the “cure” side of the NHS would be tailored to the needs of local populations. So, rather than having a “one size fits all” capability, some areas will utilise another’s capability in a particular service because they themselves do not have sufficient demand amongst their local population to justify having a local capability. Further, this side of the NHS would be funded by an insurance taken out via the current National Insurance system. This would mean a system similar to that in France; a system that would allow specialisation and excellence, reduce redundant capacity, discourage time wasters (as time wasting GP visits, broken appointments and hoax ‘999’ calls would have a financial consequence) and be transparently funded so that increased demand from the public would result in specific increases in NI to pay for it. Is it free at the point of delivery? No, not for visits to a GP or for medicines; but GP fees would be refunded unless they were a waste of time and medicines aren’t free now in most cases. Again, costs would be refunded.

Would this lead to “zero tolerance” or “rationing”?

Yes, but less so than the way we are headed at present: If the nation looks after its own health by trying to prevent illness, demand on the system will drop as will financial pressure. If we dump the “everyone does everything” model, less waste will occur. If we stop political “tinkering” we will allow stability and not incur excessive costs for changes in management / management consultancy fees.

Sources:

The National Audit Office: NHS Accounts

The NHS: employment figures and changes

The Department of Health: Research and statistics

Note: The views expressed in this paper are solely those of the authors and do not necessarily represent the policies of SVP (UK) or any of its associated companies.